Standardized Patient Form

|  |  |
| --- | --- |
| ***Role Player****: Asking someone to imagine that they are either themselves or another person in a particular situation. ​Role Players behave exactly as they feel that person would, thus would not need a case developed.*  ***Structured Role Play:*** *A person who has been provided a prepared script on one element of a scenario which articulates a learning objective.​ Improvisation meets structure.​*  ***Embedded Participant​:*** *An individual who is trained or scripted to play a role in a simulation encounter in order to guide the scenario based on the objectives.​*  ***Simulated Patient:*** *A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In performing the simulation, the SP presents the ‘Gestalt’ of the patient being simulated; not just the history, but the body language, the physical findings and the emotional and personality characteristics as well.*  ***Standardized Patient:*** *Individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way (where portrayal/presentation varies based only on learner performance are trained to behave in a highly repeatable or standardized manner in order to give each learner a fair and equal chance.*  *\*Please consider the lines between the six applications as porous and not as hard lines that prevent movement between applications . Source: Comprehensive Healthcare Simulation; Implementing Best Practices in Standardized Patient Methodology, Chapter 5 The Human Simulation Continuum: Integration and Application.* | |
| **Level of Standardization** | [ ] Standardized Patient  [ ] Simulated Patient |
| **Standardized Patient Objectives** | Your challenge as the **Standardized Patient** is multifold:   * To appropriately and accurately reveal the facts about the role being portrayed. * To improvise only when necessary and in a manner that is consistent with the overall tone/content of the case. * Maintain the realism of the simulation i.e., stay in character. * Evaluate learners fairly based on how they performed in this encounter. * Provide patient perspective in feedback. |

**Patient Name: John Smith**

**Age: 68**

**Gender: Male**

**Chief Complaint: Palpitations and shortness of breath**

**Presentation and Resulting Behaviors (e.g. body language, non-verbal communication, verbal characteristics)**

**Examples:**

**Affect: pleasant/cooperative/irritated**

**Speech: verbose/terse/limited**

***Note: include any changes to presentation as case progresses***

|  |
| --- |
| **Affect: Anxious but cooperative**  **Speech: Clear, moderate pace, slightly hurried when discussing symptoms**  **Body Language: Fidgets with hands occasionally, sits upright, avoids prolonged eye contact when discussing symptoms**  **Non-Verbal Communication: Shows signs of discomfort when describing palpitations (e.g., slight hand tremor, shallow breathing)** |

**Opening Statement, Open-Ended Questions, and Guidelines for Disclosure**

Note: this section is to give the SP guidance on how to answer open-ended questions. Scripted answer(s) to initial open-ended questions like “what brings you in today?” and “Can you tell me more?” should go in Box A. Further open-ended questions like “anything else going on?” should go in box B below, as well as any information the SP should volunteer at the first given opportunity. Box C is for information that the SP should freely offer, but wouldn’t consider mentioning until the learner introduces a relevant topic. Box D is for information that needs to be withheld unless specifically asked, (e.g. things the patient doesn’t remember until prompted or things the patient may feel shame about).

*Example: let’s say the patient’s roommate is ill. If the patient is having similar symptoms, that information probably goes in box B–it’s highly relevant to the patient and on the top of their mind. If the patient has somewhat differing symptoms, the information might go in box C and could be revealed if the learner brings up living situation, social support, or sick contacts. If the patient would assume the roommate’s illness is unrelated, the information might go in box D and only be revealed when the learner asks about sick contacts.*

|  |  |
| --- | --- |
| **Opening Statement(s)** | **A**  **"Hi, I'm John Smith. I'm here today because I've been feeling really off lately."**  **"I've been experiencing some irregular heartbeats and it's been making me feel short of breath."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **"Sometimes I feel dizzy after these episodes."**  **"I have a history of high blood pressure."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **"I live alone since my wife passed away a few years ago."**  **"I recently started a new medication for my blood pressure."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **"I have no idea what's causing this; I'm really scared it might be something serious."**  **"I haven't been taking my medications regularly because I forget sometimes."** |

**Sample Healthcare Interview & Physical Exam Format:**

**History of Present Illness (HPI):**

|  |  |
| --- | --- |
| **Quality/Character** | **Irregular, rapid heartbeats; sensation of fluttering in the chest** |
| **Onset** | **Started approximately two weeks ago** |
| **Duration/Frequency** | **Episodes last from a few minutes to several hours; occurring multiple times a day** |
| **Location** | **Heart** |
| **Radiation** | **No radiation** |
| **Intensity (e.g. 1-10 scale for pain)** | **Rates palpitations as 7/10 in severity** |
| **Treatment (what has been tried, what were the results)** | **Tried resting and deep breathing; over-the-counter beta-blockers provided minimal relief** |
| **Aggravating** **Factors (what makes it worse)** | **Physical exertion, stress** |
| **Alleviating** **Factors (what makes it better)** | **Rest, lying down** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Increased stress at work, recent illness** |
| **Associated** **Symptoms** | **Shortness of breath, dizziness, occasional chest discomfort** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Impacting daily activities, causing significant anxiety; concerned about underlying heart condition** |

**Review of Systems: (list any additional pertinent positives and negatives from these systems: Constitutional, Skin, HEENT, Endocrine, Respiratory, Cardiovascular, Gastrointestinal, Urinary, Reproductive, Musculoskeletal, Neurologic, Psychiatric/Behavioral)**

|  |
| --- |
| Constitutional: Weight stable, no fever  Skin: No rashes  HEENT: No headaches, no vision changes  Endocrine: History of hypertension  Respiratory: Shortness of breath during episodes  Cardiovascular: Palpitations, irregular heartbeat  Gastrointestinal: No nausea or vomiting  Urinary: No changes  Reproductive: N/A  Musculoskeletal: No chest pain, no joint pain  Neurologic: Dizziness during episodes  Psychiatric/Behavioral: Increased anxiety related to symptoms |

**Past Medical History (PMH): (fill in any relevant fields)**

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | **Hypertension diagnosed 10 years ago** |
| **Hospitalizations** | **None** |
| **Surgical History** | **Appendectomy at age 30** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual blood pressure checks, colonoscopy five years ago** |
| **Medications (Prescription, Over the Counter, Herbal/Dietary Supplements)**  **Include: medication name, dosage strength, dosage form, route of administration, frequency of administration, duration of therapy, indication** | **Lisinopril 20 mg orally once daily for hypertension**  **Occasionally takes over-the-counter beta-blockers for palpitations** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **No known drug allergies** |
| **Gynecologic History** | **Not applicable** |

**Family Medical History: (fill in any relevant fields)**

|  |  |
| --- | --- |
| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | **Father: Deceased at 75 due to myocardial infarction**  **Mother: Alive, age 90, with osteoporosis**  **Siblings: One sister, age 65, with type 2 diabetes** |
| **Instructions for SP on how to answer questions about any family members not listed above:**  **(i.e. do not add any additional family members, any other family is alive and well, unsure about paternal grandparents, etc.)** | **Do Not Add Additional Family Members: Only mention the father, mother, and sister as listed. If asked about other family members (e.g., grandparents, aunts, uncles, cousins), respond that there are no other significant health issues in the family.**  **Grandparents: If asked about grandparents, respond with "I'm not sure about their health history," or "I don't have much information about them."**  **Extended Relatives: For questions about aunts, uncles, or cousins, say "No other family members have any significant health problems that I'm aware of."**  **Assume All Other Family Members Are Alive and Well: Unless specifically asked about a particular relative already listed, indicate that other family members are alive and do not have health issues.**  **Consistency: Maintain consistency by not introducing new family members or health conditions unless it aligns with the information in Boxes A-D.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Management/Treatment of Relevant Conditions: Father had coronary artery disease; sister manages diabetes with diet and metformin** |

**Social History: (fill in any relevant fields)**

|  |  |  |
| --- | --- | --- |
| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | **Denies recreational drug use** |
| **Tobacco Use** | **Smoked one pack per day for 40 years, quit 5 years ago** |
| **Alcohol Use** | **Drinks socially, approximately 2-3 drinks per week** |
| **Home Environment** | **Home type** | **Lives alone in a single-story house** |
| **Home Location** | **Suburban area** |
| **Co-habitants** | **No children living nearby** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Limited family support; few close friends** |
| **Financial** | **Fixed income from pension; manages expenses** |
| **Health care access and insurance** | **Medicare** |
| **Religious or Community Groups** | **Attends local community center events** |
| **Education and Occupation** | **Level of Education** | **High school diploma** |
| **Occupation** | **Retired factory worker** |
| **Health Literacy** | **Moderate** |
| **Sexual History:** | **Relationship Status** | **Widowed** |
| **Current sexual partners** | **None** |
| **Lifetime sexual partners** | **Previously married, no current partners** |
| **Safety in relationship** | **N/A** |
| **Sexual orientation** | **Heterosexual** |
| **Gender identity** | **Pronouns** | **He/Him** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender male** |
| **Sex assigned at birth** | **Male** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Traditional male attire, maintains typical male body language** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys gardening and reading** |
| **Recent travel** | **Vacationed locally within the past year** |
| **Diet** | **Typical day’s meals** | **Balanced diet, low-sodium** |
| **Recent meals** | **No recent changes** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Avoids high-sodium foods due to hypertension** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Low-sodium diet** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks daily for 30 minutes** |
| **Recent changes to exercise/activity (and reason for change)** | **No recent changes** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern, Length, Quality: Sleeps 6-7 hours per night, generally restful**  **Recent Changes: No significant changes** |
| **Stressors** | **Work** | **Retired, no current work-related stress** |
| **Home** | **Living alone** |
| **Financial** | **Managing on a fixed income** |
| **Other** | **Concern about health and palpitations** |

**Physical Exam Findings: (may also include instructions on simulating/replicating/reporting findings, e.g., physical simulations, verbal prompts, findings cards, moulage, hybrid technology)**

|  |
| --- |
| Vital Signs: (To be provided by facilitator)  General Appearance: Alert, oriented, appears anxious  HEENT: PERRLA, EOMI, no jugular venous distension  Cardiovascular: Irregularly irregular heartbeat, no murmurs  Respiratory: Clear to auscultation bilaterally, no wheezes or crackles  Abdomen: Soft, non-tender, no hepatosplenomegaly  Extremities: No edema  Neurological: Alert, no focal deficits  Skin: Warm, dry, no rashes |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | **"I'm really worried that something serious might be wrong with my heart."**  **"Is there a chance I might need surgery?"** |
| **Questions the SP will ask if given the opportunity** | **"What tests will you be performing today?"**  **"How can I manage these symptoms better?"**  **"Are there any lifestyle changes I should consider?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **A preliminary diagnosis of atrial fibrillation, discussion of potential treatment options such as medication or procedures, and reassurance about managing the condition.** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **No. All relevant information is shared during the encounter. However, the SP should be prepared to withhold certain information (Box D) unless specifically asked, such as occasional non-compliance with medication.** |